Colorado Division of Professions and Occupations
Office of Licensing—Medical
1560 Broadway, Suite 1350
Denver, CO 80202
Phone: (303) 894-7800 / Fax: (303) 894-7693
www.dora.colorado.gov/professions

APPLICATION FOR ORIGINAL LICENSE—PHYSICIAN

APPLICANT INSTRUCTIONS

Mandatory Practice Act. Colorado has a mandatory practice act, which means that you may not practice as a Physician in this state without an active Colorado license. Submission of this application does not guarantee licensure. Therefore, do not make life or career decisions based on the probability that you may receive a license. Plan ahead for the time it will take for us to receive all required documents and complete our evaluation.

No Temporary Licenses or Provisional Permits. Colorado law does not provide for temporary licenses or provisional permits. No person may practice medicine in the state of Colorado until s/he has been authorized to do so by the Board.

Basic Requirements. Requirements for licensure are outlined in the Medical Practice Act and the Board's rules and policies. The Medical Practice Act and complete rules and policies are available online at www.dora.colorado.gov/professions/physicians.

In compliance with the Michael Skolnik Medical Transparency Act of 2010, all applicants are required to complete and maintain an online Healthcare Professions Profile on our website at www.dora.colorado.gov/professions/hppp.

To better understand Colorado's medical licensure requirements, also review the following informational documents located at the end of this application:

- Summary of Requirements for: U.S. and Canadian Medical School Graduates or International Medical School Graduates
- USMLE Information Sheet

About the Application. This application is to be completed by you and returned to the Office of Licensing. All questions on the application are mandatory, and all supporting documents must be submitted with the application. You may copy as many forms as needed; however, each form submitted must be completed in original ink or typed. Keep a copy of the completed application for your records.

Application Expiration. Your application will be kept on file for one (1) year from date of receipt in the Division. Your file and all supporting documentation will be purged if you do not submit required documents and complete your application process in one year. You will need to resubmit a new application packet and fee after that time.

Social Security Number is Required. Effective January 1, 2009, a Social Security Number is required for all licensees. The Division will consider an application to be incomplete when the applicant fails to submit his/her Social Security Number. Exceptions are made for foreign nationals not physically present in the United States and for non-immigrants in the United States on student visas who do not have a Social Security Number. These applicants must submit a signed Social Security Number Affidavit in lieu of a Social Security Number. The affidavit is available on our website at www.dora.colorado.gov/professions/physicians, or you may call (303) 894-7800 to request that one be mailed to you.

Disclosure of Addresses. Consistent with Colorado law, all addresses and phone numbers on record with the Division are public record and must be provided to the public when requested. It is your responsibility to keep your address and contact information up-to-date in our database. All letters, renewal notices, and licenses are mailed to the last known address of record. **If your address is not current, it is possible you will not receive important documents.** You can change your address online by using Online Services at www.dora.colorado.gov/professions/onlineservices.

License Expiration Grace Period for New Applicants. All new applicants who are issued a license within 120 days of the upcoming renewal expiration date will be issued a license with the subsequent expiration date. For example, licenses issued between January 1, 2013 and April 30, 2013 will reflect a license expiration date of April 30, 2015. Licenses issued prior to January 1, 2013 will reflect an expiration date of April 30, 2013 and must renew in the upcoming renewal period.

- All Physician licenses expire on April 30 of odd-numbered years and must be renewed to continue practicing.

Checking Your Application Status. Visit Online Services at www.dora.colorado.gov/professions/onlineservices to track your application from the date we log it in our database to the date your license is printed. Please allow us enough time to receive the application through the mail and enter your application into our database before you check the website. We recommend waiting at least 10 business days from date of mailing before checking the status of your application.

APPLICANT CHECKLIST

To apply for a Colorado **Physician** license:

☐ **Complete the attached application.** Return the completed application and all supporting documentation to the Office of Licensing.

☐ **Enclose the non-refundable application processing fee.** See page 1 of the application form for current fees. Fees may be paid by a check or money order drawn in U.S. dollars on a U.S. bank and **made payable to *State of Colorado***. All fees are **non-refundable** and subject to change every July 1.

☐ **Complete and return the attached Affidavit of Eligibility form.** Pursuant to C.R.S .24-34-107, all applicants for licensure are required to complete and sign an Affidavit of Eligibility, and may also be required to provide a copy of a secure and verifiable document.

☐ **Provide documentation of any name change.** If your name has changed since you obtained a previously-issued license, or if your name is different on any of your supporting documentation, you must provide a copy of the legal document verifying the name change (i.e., marriage license, divorce decree, or court order).

☐ **Submit a legible copy of your birth certificate or U.S. passport.**

☐ **Request the school where you received your medical training provide a completed Certificate of Medical Education form** (Form **L2** attached) **directly to this office.**

☐ **Request the appropriate examining agency submit an original certification of scores directly to this office.**

- ► Contact the appropriate agency to request scores: i.e. ECFMG, Medical or Osteopathic National Boards, FLEX, USMLE, LMCC, or state written exam.

☐ **If you have received and/or completed qualifying postgraduate training approved by the ACGME/AOA, request the facility where you received your training provide a Certificate of Completion of ACGME/AOA Postgraduate Training** (Form **L3** attached) **directly to this office.**

- ► A Certificate of Completion of ACGME/AOA Postgraduate Training form is mandatory for verification of the first year of training. Further training may be verified either by a letter from the training program or completion of the attached form.

☐ **Request to have original license verification from each licensing agency of all jurisdictions where you have ever been licensed (including educational or temporary permits) sent directly to this office.**

- ► Contact each jurisdiction to determine if there is a fee for license verification.

☐ **Submit a completed Report of Practice History form** (Form **L6** attached)**.**

- ► Include all work history in chronological order since completion of medical school, including all internship, residency, and fellowship training programs and non-medical employment.
- ► Request original letters of reference for the last five (5) years. Letters must be provided directly to the Board from the original source on letterhead, with dates listed as month/year.

☐ **Complete an Online Self-Query for the National Practitioner's Data Bank (NPDB), and the Healthcare Integrity and Protection Data Bank (HIPDB) and submit the results.**

- ► For instructions, contact NPDB-HIPDB at www.npdb-hipdb.hrsa.gov, or by phone at (800) 767-6732.
- ► Upon receipt of the results, send both reports (NPDB-HIPDB) directly to this office.

☐ **Complete and submit the Disciplinary Action Report form** (Form **L7** attached) **directly to the Federation of State Medical Boards.** Do not send the request form to the Office of Licensing as this will delay your application processing. When the FSMB receives the request form from you, they will provide the Disciplinary Action Report directly to the Colorado Board.

- ► You may also request this information through FSMB at www.fsmb.org or by phone at (817) 571-2949.

☐ **Provide proof of Colorado malpractice insurance or letter of exemption**. Refer to attached instructions.

(continued on next page)

APPLICANT CHECKLIST (Continued)

☐ **Complete an online Healthcare Professions Profile.** Once your application is received and entered into the Division of Professions and Occupations database, you must create a Healthcare Professions Profile on our website at www.dora.colorado.gov/professions/hppp. You may begin checking the Healthcare Professions Profiling Program (HPPP) website within a few days of submitting your application. If you cannot create your profile within 14 days of submitting your application, or if you have questions or technical issues regarding your online profile, contact the Healthcare Professions Profiling Program at (303) 894-5942. **Your application is not considered complete, and a license will not be issued until you have submitted the online profile.**

In addition to the above, International Medical School Graduates must also:

☐ **Submit a completed International Medical Graduates Questionnaire form** (Form **L8** attached)**.**

- ► If Board certified, request certification from the specialty board be sent directly to this office.

☐ **Contact ECFMG to request an "ECFMG Certification Status Report"** – at www.ecfmg.org or by phone at (215) 386-5900.

FEDERATION CREDENTIALS VERIFICATION SERVICE (FCVS) APPLICANTS:

The Colorado Medical Board accepts documents from FCVS. This service is optional. For more information, please visit the Federation of State Medical Boards website at www.fsmb.org.

If you elect to use FCVS, you must still:

☐ **Submit a completed Application for Original License.**

☐ **Enclose the non-refundable application processing fee.**

☐ **Complete and return the attached Affidavit of Eligibility form.**

☐ **Provide documentation of any name change.**

☐ **Request original license verification from each licensing agency of all jurisdictions where you have ever been licensed (including educational or temporary permits).**

☐ **Submit a completed Report of Practice History Form** (Form **L6** attached) **and request appropriate letters of verification for the last five years directly from the source.**

☐ **Provide proof of Colorado malpractice insurance or letter of exemption.**

☐ **Submit the results of your National Practitioner's Data Bank (NPDB), and Healthcare Integrity and Protection Data Bank (HIPDB) Self-Queries.**

☐ **Complete a Healthcare Professions Profile in compliance with the Michael Skolnik Medical Transparency Act of 2010.**

☐ International Medical School Graduates only: **Submit a completed International Medical Graduates Questionnaire form** (attached). If Board certified, request certification from the specialty board be sent directly to this office.

Return your completed application packet and all supporting documentation to:

Division of Professions and Occupations
Office of Licensing—Medical
1560 Broadway, Suite 1350
Denver, CO 80202

Department of Regulatory Agencies

Lauren Larson
Director, Division of Professions and Occupations

IMPORTANT NOTICE

TO: All Applicants

FROM: Director of the Division of Professions and Occupations

SUBJECT: Licensure and Criminal History

Thank you for your interest in becoming a licensed* professional within the Division of Professions and Occupations. Before you submit your application, please be aware of a few facts regarding criminal conduct, convictions, and disciplinary actions in other states.

The mission of the Division of Professions and Occupations is "public protection through effective licensure and enforcement." One way the Division safeguards consumers is by issuing licenses to fully qualified, competent, and ethical applicants.

During the licensing process – and depending on the specific application – the Division may ask whether you have ever been disciplined in any state, arrested, charged, convicted, or pled guilty to a crime. An arrest, subsequent criminal conviction, or disciplinary action is not an automatic disqualification from licensure. Rather, the appropriate board or program will look at the facts surrounding the criminal conduct and disciplinary action in addressing your license application. You should know that licensure is a privilege, not a right. One thing you must do to obtain the privilege is to be complete and accurate in disclosing information on your application.

Be sure to list all relevant complaints, disciplinary actions, arrests, charges, or convictions in response to the appropriate licensure questions. **Failure to fully and accurately disclose requested criminal history information, alone, could constitute grounds for denial of your application or revocation of your license.** When requested, you must include information regarding prior conduct. This remains the case when the conduct is seemingly unrelated to the activities of a profession, and when the conduct involves deferred sentences or judgments.

Remember, even following licensure, you are still required to notify your professional licensing board or program about subsequent convictions and disciplinary actions in other states.

Please be aware that the Division conducts audits of its licensing database against several criminal and national disciplinary databases. This allows the Division to verify the truthfulness of your application and track subsequent criminal and disciplinary conduct after initial licensure. Keep in mind, your license will not necessarily be revoked, or your application denied, if you have been disciplined, arrested, charged or convicted. But, you will most likely be denied or revoked if you fail to disclose requested information.

**The word "license" is used as a general term. While most of the professions and occupations are licensed, others may be registered, certified, or listed. For precise terminology and requirements related to a profession or occupation, please consult the website of the appropriate board or program.*

Colorado Department of Regulatory Agencies
Division of Professions and Occupations
1560 Broadway, Suite 1350
Denver, CO 80202

Licensee/Applicant Full Legal Name

Last	First	Middle	Suffix

Colorado Professional or Occupational License/Certification/Registration Number: _____
(if already licensed)

Professional or Occupational License/Certification/Registration type applying for: _____

AFFIDAVIT OF ELIGIBILITY

Pursuant to H.B. 06S-1009, C.R.S. 24-34-107, ALL applicants for original licensure* or licensees renewing or reinstating a current Colorado license after January 1, 2007 are required to complete and sign this Affidavit of Eligibility.

**The word "licensure" is used as a general term. While most of the professions and occupations are licensed, others may be certified, registered, or listed. For precise terminology and requirements related to a profession or occupation, please consult the website of the appropriate board or program.*

Section A: LAWFUL PRESENCE in the United States

1. ☐ I am a U.S. citizen. Check one of the acceptable secure and verifiable documents in Section B that applies and fully complete the information requested. Complete documentation must be provided upon request.
2. ☐ I am not a U.S. citizen, but I am lawfully present in the U.S. and authorized by the Department of Homeland Security to be employed in the U.S. Check one of the acceptable secure and verifiable documents in Section B that applies and fully complete the information requested. Complete documentation must be provided upon request.
3. ☐ I am not physically present in the U.S. under 8 U.S.C. sec. 1621 (c)(2)(c) or employed in the U.S. pursuant to 8 U.S.C. sec. 1621 (c)(2)(a). Check one option, a or b below, then skip to Section C. (Do not complete Section B.)
   a. ☐ I am a U.S. citizen, not physically present or employed in the United States.
   b. ☐ I am a Foreign National, not physically present or employed in the United States.

Section B: SECURE AND VERIFIABLE DOCUMENTS
Select ONE document in this section if you checked 1 or 2 in Section A.

Government Issued Identification	Name of state agency or federal agency that issued the document	Full name as shown on driver's license or state/federal issued ID	License/ID Number	Expiration Date (mm/dd/yyyy)
☐ Driver's license or permit				
☐ Government issued ID card				
☐ Valid U.S. military ID/common access card				
☐ Colorado Department of Corrections inmate ID				
☐ Tribal ID card				
☐ U.S. passport				
☐ Certificate of Naturalization				

Section B: SECURE AND VERIFIABLE DOCUMENTS (continued)

Government Issued Identification	Name of state agency or federal agency that issued the document	Full name as shown on driver's license or state/federal issued ID	License/ID Number	Expiration Date (mm/dd/yyyy)
☐ Certificate of (U.S.) Citizenship				
☐ Valid Temporary Resident card				
☐ Valid I-94 issued by Canadian government				
☐ Valid I-94 with refugee/asylum stamp				

☐ Valid I-766 (Employment Authorization Card) — **Issuing federal agency:**

Name on card	Alien Number (A#)	Card Number	Valid from (mm/dd/yyyy)	Expires (mm/dd/yyyy)

☐ Valid I-551 (Resident Alien or Permanent Resident Card) — **Issuing federal agency:**

Name on card	Alien Number (A#)	Country of birth	Card expires (mm/dd/yyyy)	Resident since (mm/dd/yyyy)

☐ Valid foreign passport with an unexpired visa with proper classification for work authorization, and an unexpired I-94

Issuing foreign country	Passport Number	Visa Number	Visa Class (ex.: J-1, P-1, H-1B, etc.)	Date of entry (mm/dd/yyyy)	Until date (mm/dd/yyyy)

☐ Valid foreign passport bearing an unexpired "Processed for I-551" stamp or with an attached unexpired "Temporary I-551" visa

Issuing foreign country:	Passport Number:

Section C: ATTESTATION

- I understand that this sworn statement is required by law because I have applied for or hold a professional or commercial license regulated by 8 U.S.C. sec. 1621. I understand that state law requires me to provide proof that I am lawfully present in the United States when asked as well as submission of a secure and verifiable document. I may also be required to provide proof of lawful presence.
- I understand that in accordance with sections 18-8-503 and 18-8-501(2)(a)(I), C.R.S., false statements made herein are punishable by law. I state under penalty of perjury in the second degree, as defined in 18-8-503, C.R.S. that the above statements are true and correct.
- I am the person identified above and the information contained herein is true and correct to the best of my knowledge. I understand that under Colorado law, providing false information is grounds for denial, suspension or revocation of a license, certificate, registration or permit.
- I understand that the above information must be disclosed to the Department of Regulatory Agencies upon request and is subject to verification.

Print Full Legal Name

Signature (Full Name) Date

Division of Professions and Occupations
Office of Licensing–Medical
(303) 894-7800 / Fax (303) 894-7693
www.dora.colorado.gov/professions

Application for Original License
PHYSICIAN
Fee: $544

The content of this application must not be changed. If the content is changed, the applicant may be referred to the Colorado State Attorney General's Office for violation of Colorado law.

Fees may be paid by a check or money order drawn in U.S. dollars on a U.S. bank and made payable to *State of Colorado*.

PART 1—APPLICANT INFORMATION

Name: Last:	☐ MD ☐ DO	First:	Middle:	Suffix:
Previous Name(s):				
Social Security Number: *	**Date of Birth** (mm/dd/yyyy)**:**		**Gender:** ☐ Male ☐ Female	
Place of Birth (city and state, or foreign country)**:**				
Mailing Address: *This is a* ☐ *Home* ☐ *Business*	PO Box, Street: City, State, Zip:			
Daytime Telephone Number: ( )	**E-mail Address:** *Preferred method for communication:* ☐ *Mail* ☐ *E-mail*			

PART 2—EDUCATION / TRAINING

List the name and address of the school where your medical degree was received:

Name of School	Location (address and ZIP)	Years Attended (from / to)	Year of Graduation

► If this is an international medical school, please provide the country where the school is physically located: _____

Have you received and/or completed qualifying postgraduate training approved by the ACGME/AOA in U.S. or Canadian programs? ☐ YES ☐ NO

► If **YES,** provide information below:

Name of Facility	Specialty	Years Attended (from / to)

What is your specialty or specialties?

***Social Security Number Disclosure:** Section 24-34-107(1) of the Colorado Revised Statutes requires that every application by an individual for a license issued pursuant to the authority set forth in Title 12, C.R.S., by the Department of Regulatory Agencies, shall require the applicant's Social Security Number. Disclosure of your Social Security Number is mandatory for purposes of establishing, modifying, or enforcing child support under Sections 14-14-113 and 26-13-126, C.R.S.; locating an individual who is under an obligation to pay child support as required by Section 26-13-107(3)(a)(I)(A), C.R.S.; and reporting to the National Practitioner Data Bank pursuant to 45 CFR Sections 60.1 et seq., and the Health Integrity and Protection Data Bank as required by 45 CFR Sections 61.1 *et seq*. Failure to provide your Social Security Number for these mandatory purposes will result in the denial of your licensure application. Disclosure of your Social Security Number is voluntary for disclosure to other state regulatory agencies, testing and examination vendors, law enforcement agencies, and other private federations and associations involved in professional regulation. Your Social Security Number will not be released for any other purpose not provided for by law.

OFFICE USE ONLY **LICENSE NUMBER:** _____ **DATE ISSUED:** _____

APPLICANT NAME: _____

PART 3—EXAMINATION / CERTIFICATION

List name of licensing exam(s): ECFMG, Medical or Osteopathic National Boards, FLEX, USMLE, LMCC, or state written exam.

Exam	Location	Date	Result

► If this is an international medical school, please provide the country where the school is physically located: _____

Are you Board certified by either the American Board of Medical Specialties or the American Osteopathic Association? ☐ YES ☐ NO

► If **YES,** list certification information: _____

PART 4—LICENSE INFORMATION

A. Have you ever been licensed to practice medicine in any state, territory, district, or country? (include temporary licenses and educational permits) ☐ YES ☐ NO

► If **YES**, provide a complete list of all medical licenses (if needed, attach an additional sheet in the same format):

Type of license	State/Country	License Number	Year license issued	Disciplinary action against license?	Is this license current/active?
				☐ YES ☐ NO	☐ YES ☐ NO
				☐ YES ☐ NO	☐ YES ☐ NO
				☐ YES ☐ NO	☐ YES ☐ NO

B. Have you ever applied for any type of Colorado health care license prior to this application? ☐ YES ☐ NO

► If **YES**, provide application types and license information if applicable:

Application type	License Number	Month and year license issued

PART 5—MALPRACTICE INSURANCE CERTIFICATION

You must provide proof of malpractice insurance or an acceptable alternative as required by Colorado law, or claim one of the exemptions set forth in the enclosed insurance memo. See instructions in the insurance memo, and include proof of insurance (obtained from your insurance carrier) or **include a statement setting forth the basis for the exemption claimed below.**

Exemption Claimed: _____

APPLICANT NAME: _____

PART 6—SCREENING QUESTIONS

1. Have you ever been notified by any state, territory, district, or country, U.S. government agency, or state medical/osteopathic licensing board of any complaint, investigation, or inquiry which is currently pending? ☐ YES ☐ NO

   ► If **YES,** give details below AND request official complaint and/or investigative report be sent directly to the Board from the licensing body, as well as personally submit a narrative regarding the complaint.

Agency	Date	Charge	Disposition

2. Has any healing arts license which you now hold or have ever held been admonished, reprimanded, censured and/or disciplined in any way by any licensing agency in another state or country, by any peer review committee or body, by any healthcare facility or committee thereof, by any professional or medical society or association or committee thereof, or by any governmental agency, law enforcement agency or court of law? (Disciplinary actions include, but are not limited to, any allegations currently pending.) Washington licensees must disclose any Stipulation to Informal Disposition in response to this question. ☐ YES ☐ NO

   ► If **YES,** give details below AND request all official disciplinary documents including initial complaint, stipulations, orders or reprimands be sent directly to the Board, as well as a narrative regarding the action taken.

Agency	Date	Charge	Disposition

3. Have you ever entered into any agreement with any state, territory, district, country, U.S. government agency, and state medical/osteopathic board regarding your medical license? ☐ YES ☐ NO

   ► If **YES,** give details below AND request all official disciplinary documents including initial complaint, stipulations, orders or reprimands be sent directly to the Board. Also submit your narrative regarding the action taken.

Agency	Date	Reason

4. Have you ever been denied a license, permission to practice medicine or any other healing art, or permission to take an examination in any state, country, or U.S. federal jurisdiction? ☐ YES ☐ NO

   ► If **YES,** give details below AND request all official disciplinary documents including initial complaint, stipulations, orders, agreements or reprimands be sent directly to the Board. Also submit your narrative regarding the action taken.

Agency	Date	Reason for Denial

5. Have you ever voluntarily surrendered a license to practice medicine or any other healing arts in any other state, country, or U.S. federal jurisdiction? This does not include allowing your license to expire solely due to non-payment of the renewal fee. ☐ YES ☐ NO

   ► If **YES,** summarize below AND request all official disciplinary documents including initial complaint, stipulations, orders, agreements or reprimands be sent directly to the Board. Also submit your narrative regarding the action taken.

Agency	Date	Reason

APPLICANT NAME: _____

PART 6—SCREENING QUESTIONS (Continued)

6. Have either your medical staff membership or clinical privileges at any hospital or healthcare facility or your DEA registration been voluntarily or involuntarily reduced, limited, placed on probation, not renewed or relinquished or have either been denied, revoked or suspended? You must answer YES if any of these actions are currently pending. You must answer YES if you have withdrawn or failed to proceed with an application for these items. ☐ YES ☐ NO

   ► If **YES,** summarize below AND request hospital or DEA to submit a report directly to the Board regarding the action. Also submit your narrative regarding the action taken.

Name of Facility	Date	Reason for Action

7. Have you ever been charged, indicted, convicted, received a deferred prosecution, received a deferred judgment and sentence, entered a plea of guilty, entered a plea of nolo contendere, or been placed on adult diversion for any violation of any law? Note: It is unnecessary to report traffic offenses that do not involve alcohol or drugs. ☐ YES ☐ NO

   ► If **YES,** summarize below AND submit your narrative regarding the incident as well as court and police records and information regarding final disposition of the case.

Date	Court	Violation	Penalty or Disposition

8. Do you now abuse or excessively use, or have you in the last five years abused or excessively used, any habit forming drug, including alcohol, or any controlled substance that has a) resulted in any accusation or discipline for misconduct, unreliability, neglect of work, or failure to meet professional responsibilities; or b) affected your ability to practice as a physician safely and competently? ☐ YES ☐ NO

9. In the last five years, have you been diagnosed with or treated for a condition that significantly disturbs your cognition, behavior, or motor function, and that may impair your ability to practice as a physician safely and competently including but not limited to bipolar disorder, severe major depression, schizophrenia or other major psychotic disorder, a neurological illness, or sleep disorder? ☐ YES ☐ NO

You may answer NO to Question 8 or 9 if the behavior or condition is already known to the Colorado Physician Health Program (CPHP). "Known to CPHP" means that you have informed CPHP of your behavior or condition and you are complying with all of CPHP's requirements for evaluation, treatment, and/or monitoring.

If you answer YES to Question 8 or 9, submit detailed information to the Board that will allow the Board to assess your ability to practice safely, competently, and without impairment to your professional judgment, skill, or knowledge. In addition to that information, you are required to provide copies of any related records, reports, evaluations, police reports, probation reports, and court records directly to the Board.

Please be advised that an affirmative response to Question 8 or 9 *may result in* a request from the Board for evaluation by the Colorado Physician Health Program (CPHP). The CPHP evaluation process could potentially delay consideration of an application. Therefore, the Board is providing advance notice of this possibility so that applicants may contact CPHP to schedule an evaluation at the beginning of the application process. By doing so, the application for licensure should not be unduly delayed. An applicant is not required to contact CPHP in advance of Board consideration of the application. The applicant may choose to wait for a specific decision by the Board that a CPHP evaluation is necessary. This information is being provided to put applicants on notice with respect to this potential requirement and afford the applicant the opportunity to expedite the process if he or she so desires. (Colorado Physicians Health Program – CPHP, 899 Logan Street, #410, Denver, CO 80203; (303) 860-0122.)

APPLICANT NAME: _____

PART 6—SCREENING QUESTIONS (Continued)

10. Within the last five years, has any final judgment, settlement or arbitration award for medical malpractice been paid on your behalf or has any claim been filed which is still pending? ☐ YES ☐ NO

► If **YES,** summarize below AND submit to the Board a completed malpractice Claims Information Form (attached) and a clinical narrative regarding your involvement in the case.

Date	Name and Address of Insurance Company	Reason for Action

11. Have you ever been refused malpractice insurance, or has your malpractice insurance ever been canceled or rated at a higher premium due to past claims experience? ☐ YES ☐ NO

► If **YES,** submit to the Board an explanation regarding the cancellation or increase in premiums of the insurance and verification directly from the insurance company to the Board.

PART 7—MILITARY

Are you a Member of the U.S. military? ☐ YES ☐ NO

➢ If **YES**, provide information below:

Branch:	Duty Station:

PART 8—SECURITY OF PATIENT MEDICAL RECORDS

☐ By checking this box, I attest that I have developed a written plan to ensure the security of patient medical records in compliance with C.R.S. 12-36-140.

ATTESTATION

I hereby make application for a license to practice medicine in the state of Colorado. In so doing, I authorize all hospitals, institutions or organizations, my references, personal physicians, employers (past and present), business and professional associations (past and present), and all government agencies (local, state, federal and foreign), which includes state medical licensing boards and the Federation of State Medical Boards, to release to the licensing Board any information, files or records requested by the Board in connection with the processing of this application. I further authorize this Board to release to the organizations, individuals and groups listed above any information which is material to my application or pertinent to my practice of medicine during the processing of this application and the time that I am a licensee of this Board.

I state under penalty of perjury in the second degree, as defined in C.R.S. 18-8-503 that the information contained in this application is true and correct to the best of my knowledge. In accordance with C.R.S. 18-8-501(2)(a)(I), false statements made herein are punishable by law and may constitute violation of the practice act.

_____ _____

Signature of Applicant **Date**

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CERTIFICATE OF MEDICAL EDUCATION

SECTION 1

To be completed by applicant and forwarded to school where medical degree was received.

This certifies that _____
Full Name of Applicant

enrolled in _____
Full Name of School

_____ on the _____ day of _____, _____.
Location of School Day Month Year

SECTION 2

To be completed by president / secretary / dean of medical school and forwarded to the Office of Licensing.

The undersigned certifies that the records of this institution show that s/he attended this institution

beginning on the _____ day of _____, _____ and was granted the degree
Day Month Year

Bachelor/Doctor of Medicine or Doctor of Osteopathy on the _____ day of _____, _____.
Day Month Year

Signed and the college seal affixed

This _____ day of _____, _____.
Day Month Year

By _____
President / Secretary / Dean

NOT VALID WITHOUT SCHOOL SEAL

NOTE TO REGISTRAR:
If no school seal, please indicate above next to signature of President/Secretary/Dean.

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CERTIFICATE OF COMPLETION OF ACGME/AOA POSTGRADUATE TRAINING

SECTION 1

To be completed by applicant and forwarded to the facility where postgraduate training was received and/or completed.

This certifies that _____
Full Name of Applicant

a graduate of _____
Full Name of Medical/Osteopathic School

commenced postgraduate training at _____
Name and Address of Facility

SECTION 2

To be completed by the program director of the facility for ACGME/AOA postgraduate training in the United States or Canada.

on _____, _____ and satisfactorily completed or will complete such training on _____, _____.

This training consisted of _____ months of actual clinical instruction and is approved by the Accredited Council for Medical Education (ACGME), the American Osteopathic Association (AOA), or the Coordinating Council of Medical Education of the Canadian Medical Association (CCME) and consisted of the following rotations:

List type and length of training.

ROTATION	LENGTH OF ROTATION

Was this physician's performance completely satisfactory? ☐ **YES** ☐ **NO**

►If **NO**, please attach an explanation.

I hereby declare under penalty of perjury under the laws of the State of Colorado that the above statements are true and correct and the facility is approved by the ACGME/AOA or the CCME to offer the type of level of training completed by the applicant and that the applicant was trained in an approved ACGME or CCME program position.

Program Director _____

Address _____

Phone Number _____ Date _____

Signature _____

Colorado Division of Professions and Occupations
Office of Licensing—Medical
1560 Broadway, Suite 1350
Denver, CO 80202
Phone: (303) 894-7800 / Fax: (303) 894-7693
www.dora.colorado.gov/professions

REPORT OF PRACTICE HISTORY

(See instructions on following page)

	Dates of Practice From mm/yyyy	To mm/yyyy	Facility Name	Address (Street & Number, City, State, ZIP)	Reference (Name and Title)	Nature of Practice
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						

Supplying false information in an application for a license is punishable by law.

I state under penalty of perjury in the second degree, as defined in Colorado Revised Statutes 18-8-503, that the information contained in this application is true and correct to the best of my knowledge. I understand that under the Medical Practice Act, providing false information is grounds for denial, suspension or revocation of a medical license.

Applicant Signature | Applicant Last Name (print) | Date

Instructions for Completing
Report of Practice History (L6)

1. List all of your experience in medical practice <u>in chronological order</u> since completion of medical school, including:

- All internships, residency and fellowship programs;
- Clinic practice;
- Private practice;
- Any other medical practice or position;
- Any hospital that you held privileges at during the last five years, including temporary privileges and consulting privileges;
- All locum tenens positions; and
- Breaks in the practice of medicine of one month or greater.

2. Request original letter(s) of verification covering the last five years for the above.

- Each letter must be an original on letterhead addressed to Office of Licensing—Medical.
- Each letter must:
  - Verify dates of practice, including beginning month and year and ending month and year, nature of practice, and privilege status. Letters verifying employment history must list dates as month/year.
  - Include an evaluation of your skill level, aptitude, and ability to apply knowledge, and an assessment of your attitude and behavior towards your colleagues and patients.
- Letters verifying hospital privileges must be written by the chief of staff or chief administrative officer.
- Letters verifying private practice must be written by an associate or colleague.
- If contracted by a locum tenens agency, one letter from that agency verifying all positions held will suffice.
- For your training program, a *Certificate of Completion of ACGME/AOA Postgraduate Training form* (L3 attached) is mandatory for verification of the first year of training. However, further training may be verified either by a letter from the training program or with an L3 form.

<u>NOTE</u>: If you have not practiced medicine for the two years immediately preceding the filing of this application, refer to Board Rule 120 regarding Continued Competency, which is available at www.dora.colorado.gov/professions/physicians.

Colorado Division of Professions and Occupations
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REQUEST FOR FEDERATION OF STATE MEDICAL BOARDS (FSMB)—DISCIPLINARY ACTION REPORT

PHYSICIAN: To complete your application we must have a report from the Federation's National Databank of disciplinary actions taken by state licensing boards and/or other credentialing agencies. Note: an unfavorable report does not automatically disqualify you from licensure in Colorado.

Do not send this request form to the Colorado Office of Licensing.
When the FSMB receives the request form from you, they will provide the Disciplinary Action Report directly to the Colorado Board.

Complete this form and mail directly to:

Federation of State Medical Boards of the United States, Inc.
400 Fuller Wiser Road, Suite 300
Euless, TX 76039-3856

Phone: (817) 868-4000
Fax: (817) 868-4099

No fee is required.

Physician Name: Last:	☐ MD ☐ DO	First:	Middle:	Suffix:
Social Security Number:		**Date of Birth** (mm/dd/yyyy)**:**		
Address: PO Box, Street: City, State, Zip:				
Medical School:		**Date of Graduation:**		

I hereby authorize and request that the Federation of State Medical Boards of the United States, Inc. provide a disciplinary history to the following:

Colorado Division of Professions and Occupations
Office of Licensing—Medical
1560 Broadway, Suite 1350
Denver, CO 80202

Signature _____ Date _____

INTERNATIONAL MEDICAL GRADUATES QUESTIONNAIRE

This form is for international medical school graduates only. Please complete and return with your application.

SECTION 1 – SPECIALTY BOARD INFORMATION

Applicant Name: _____

Medical School: _____

1. Do you currently hold specialty board certification issued through the American Board of Medical Specialties or the American Osteopathic Association? ☐ YES ☐ NO

   ► If **YES**, please complete the following and request a letter of certification be sent directly from the specialty board to this office.

   Specialty Board: _____ Date of Certification: _____

2. If you are not Board certified, are you Board prepared? ☐ YES ☐ NO

SECTION 2 – MEDICAL SCHOOL QUESTIONS

INSTRUCTIONS:

Answer each of the questions below either YES or NO. In the case where you do not know the answer, check NO and provide an explanation on a separate sheet of paper. The mere statement that you do not know the answer is not adequate. You must make reasonable inquiry of your medical school for the information. If you have made reasonable inquiry and still have not been able to obtain the information requested, you must set out what reasonable effort you have conducted, including the names of all persons contacted in making your inquiry.

GOVERNANCE

1. At the time of your attendance, was your medical school a component of a university that had other graduate and other professional degree programs? ☐ YES ☐ NO
2. At the time of your attendance, was your medical school part of a not-for-profit university or chartered as a not-for-profit institution by the government of the jurisdiction in which it operated? ☐ YES ☐ NO

ADMINISTRATION

3. At the time of your attendance, did your medical school have a chief official or “Dean” qualified by education and experience to provide leadership in medical education? ☐ YES ☐ NO

EDUCATIONAL PROGRAM

4. At the time of your attendance, did your medical school provide at least 130 weeks of instruction? ☐ YES ☐ NO
5. At the time of your attendance, did the curriculum of your medical school include all of the following disciplines: anatomy, biochemistry, physiology, microbiology and immunology, pathology, pharmacology and therapeutics, and preventive medicine? ☐ YES ☐ NO
6. At the time of your attendance, did your medical school provide for laboratory or other practical exercises in the disciplines set out in question 5 above? ☐ YES ☐ NO
7. At the time of your attendance, did your medical school provide for clinical education programs involving actual patients in all of the following disciplines: family medicine, internal medicine, obstetrics and gynecology, pediatrics, psychiatry and surgery? ☐ YES ☐ NO
8. At the time of your attendance, were the clinical education programs mentioned in question 7 above conducted in teaching hospitals? ☐ YES ☐ NO
9. At the time of your attendance, did your medical school publicize to all faculty members and students its standards and procedures for the evaluation, advancement, and graduation of its students and for disciplinary action? ☐ YES ☐ NO

MEDICAL STUDENTS

10. At the time of your attendance, did your medical school require three or more years of undergraduate education for entrance into the medical school? ☐ YES ☐ NO
11. At the time of your attendance, were the criteria and procedures for the selection of students published and available to potential applicants and their undergraduate advisors? ☐ YES ☐ NO
12. At the time of your attendance, did your medical school provide financial aid to students? ☐ YES ☐ NO
13. At the time of your attendance, did your medical school provide a student health service available to all medical school students? ☐ YES ☐ NO

RESOURCES FOR THE EDUCATIONAL PROGRAM

14. At the time of your attendance, did your medical school only enroll the number of students that the school's total resources could accommodate? ☐ YES ☐ NO
15. At the time of your attendance, did your medical school have buildings and equipment that were quantitatively and qualitatively adequate to provide an environment conducive to high productivity of faculty and students? ☐ YES ☐ NO
16. At the time of your attendance, did the persons appointed to the faculty have demonstrated achievements within their disciplines commensurate with their faculty rank? ☐ YES ☐ NO
17. At the time of your attendance, did your medical school have a library, sufficient in size and breadth, to support the educational programs offered by the institution? ☐ YES ☐ NO
18. At the time of your attendance, did the library at your medical school have a library staff to supervise the library and to provide instruction in its use? ☐ YES ☐ NO

OTHER QUESTIONS AND REQUESTS FOR INFORMATION

1. What year was your medical school founded? _____

2. **You must, in typewritten response, explain in your own words why you feel your medical school provided a high quality medical education. In your answer, please discuss the following: How did your medical school prepare its graduates to enter and complete graduate medical education to qualify for licensure, to provide competent medical care and to have the educational background for continued learning.**

I state under penalty of perjury in the second degree, as defined in 18-8-503, Colorado Revised Statutes, that the information contained herein is true and correct to the best of my knowledge.

I understand that under the Medical Practice Act, providing false information is grounds for denial, suspension or revocation of a medical license.

_____ _____

Signature of Applicant Date

COLORADO MEDICAL BOARD
CLAIMS INFORMATION FORM

Applicant: Complete this form for each liability or malpractice claim identified in the application Screening Question regarding malpractice.

Name of Physician _____ Business Telephone Number _____

Address _____ City, State, ZIP _____

1. On a separate sheet of paper, type your full name and provide a clinical narrative regarding each malpractice case(s) / allegations. Include name of patient, age, sex, date of occurrence, and location (include address). Do not omit the answers to these questions or make reference to attached documents for answers. This section must be completed with your own description, which includes all of the facts requested above. Simply stating that the charges were dismissed is inadequate, more detail must be provided.

2. Indicate your position in case, i.e., intern, resident, primary doctor, etc. _____

3. Case was filed against: ☐ Individual doctor ☐ Group ☐ Hospital

   List names of other doctors and/or hospitals also named in the suit: _____

4. Plaintiff's Attorney and Telephone: _____

5. Is the claim pending? ☐ YES ☐ NO

6. Was there a judgment or settlement? ☐ YES ☐ NO

7. What was the amount and date of the judgment or settlement? _____

8. What amount was attributable to you, your insurance company, or your employer? _____

I certify that the information I have provided is correct to the best of my knowledge.

Signature _____ Date _____

Department of Regulatory Agencies

Division of Professions and Occupations
Lauren Larson
Director

Colorado Medical Board
Marschall S. Smith
Program Director

John W. Hickenlooper
Governor

Barbara J. Kelley
Executive
Director

M E M O R A N D U M

TO: All Applicants for Colorado Medical Licensure

SUBJECT: Malpractice Insurance Requirements for Colorado Medical Licensure

In 1988, the Colorado General Assembly enacted a law requiring all Colorado licensed physicians and all applicants for Colorado medical licensure to maintain certain amounts of malpractice insurance coverage (reference C.R.S. 13-64-301 through 304). Each Colorado licensed physician must maintain commercial professional liability insurance coverage with an insurance company authorized to do business in Colorado in a minimum indemnity amount of $1,000,000 per incident and $3,000,000 annual aggregate per year, or an acceptable alternative as set forth in Board Rule 220 (available online at www.dora.colorado.gov/professions/physicians).

YOU MUST DO THE FOLLOWING IN ORDER TO MEET THE COLORADO INSURANCE REQUIREMENT FOR LICENSURE:

A. IF you have malpractice insurance coverage valid in the state of Colorado at the time you submit your application, instruct your insurance carrier or Colorado postgraduate training program to submit an original statement directly to the Board office indicating the policy number, dates of coverage, amounts of coverage, and (for insurance companies located outside of Colorado) a statement affirming that the coverage is effective while you practice in Colorado.

B. IF you do not have the required malpractice coverage at the time of application, **and** you meet one of the numbered exemption categories set forth in Rule 200, you must provide a signed statement to the Board claiming one of the specific exemptions set forth in Rule 200. (**Example:** "I currently reside outside of Colorado, and claim exemption **D** set forth in Rule 200. I understand that before I engage in any medical practice in Colorado, I must obtain the required insurance or an acceptable equivalent.")

C. IF you do not have the required insurance coverage, and IF you do not meet one of the enumerated exemption categories set forth in Rule 200, you must obtain insurance coverage before your application will be considered complete and submitted to the Board for review. Under our law, it is not sufficient for you merely to advise the Board that you will obtain insurance following issuance of your license.

UNITED STATES AND CANADIAN MEDICAL SCHOOL GRADUATES
SUMMARY OF REQUIREMENTS

REQUIREMENTS: You may be eligible for licensure consideration when you have successfully

1. GRADUATED FROM AN APPROVED MEDICAL SCHOOL; and
2. COMPLETED ONE YEAR OF APPROVED POSTGRADUATE TRAINING; and
3. PASSED ONE OF THE FOLLOWING UNITED STATES EXAMS:

NBME and USMLE: Request scores be sent directly to the Board.

National Board of Medical Examiners
PO Box 48014
Newark, NJ 07101-4814
(215) 590-9500
Request form can be found on the National Board website: www.nbme.org

NATIONAL OSTEOPATHIC BOARD EXAM: Request scores be sent directly to the Board from:

National Board of Osteopathic Examiners
8765 West Higgins Road, Suite 200
Chicago, IL 60631
Phone: (773) 714-0622 / Fax: (773) 714 0631

LMCC: Request "Certificate of Standing" be sent directly to the Board from:

The Medical Council of Canada
PO Box/CP 8234
Ottawa, Ontario, Canada K1G 3H7
(613) 521-6012
NOTE: QE/LMCC is an acceptable examination for graduates of Canadian or U.S. medical schools only.

FLEX EXAM (see chart below for score requirements): Request certification of FLEX scores be sent directly to the Board from:

Federation of State Medical Boards of the United States, Inc.
400 Fuller Wiser Road, Suite 300
Euless, TX 76039-3856
(817) 868-4000 (www.fsmb.org)

FLEX EXAM TAKEN:	MINIMUM SCORE ACCEPTED:
Before 1985	75 weighted average; Passed in one sitting: no scrambling or replacement of scores.
Between June 1985 and December 1993	75 each component; Both components must be passed within 7 years.

USMLE: For approved combinations of NATIONAL BOARD, FLEX and USMLE or to take the USMLE Step 3, see enclosed USMLE information sheet or visit www.usmle.org.

To request scores for USMLE (or combination of USMLE and FLEX), contact FSMB at www.fsmb.org or (817) 571-2949 to request your scores.
To request scores for combinations of the USMLE and National Board, see the NBME website listed above.

UNITED STATES STATE BOARD EXAM: If you did not take any of the above national exams but did successfully pass a state-constructed exam, request state verification with scores. Applicant must have a valid unencumbered license in the state where the exam was taken or in another state where applicant was licensed by reciprocity based on the original state's exam.

INTERNATIONAL MEDICAL SCHOOL GRADUATES
SUMMARY OF REQUIREMENTS

REQUIREMENTS: You may be eligible for licensure consideration when you have successfully

1. GRADUATED FROM MEDICAL SCHOOL
   The Colorado Board reviews international medical schools on a case-by-case basis. Any questions or concerns regarding school acceptance should be directed to Board staff.
2. PASSED THE EXAMINATION REQUIRED BY THE EDUCATIONAL COMMISSION FOR FOREIGN MEDICAL GRADUATES (ECFMG). Contact ECFMG to request a Status Report of ECFMG Certification (www.ecfmg.org).
3. COMPLETED THREE YEARS OF ACGME/AOA APPROVED CLINICAL POSTGRADUATE TRAINING IN THE UNITED STATES OR CANADA.
4. PASSED ONE OF THE FOLLOWING UNITED STATES EXAMS:

NATIONAL BOARD OF MEDICAL EXAMINERS EXAM: Successfully passed all 3 parts of National Boards or a combination of NBME Parts and USMLE steps. Requests scores be sent directly to the Board.

National Board of Medical Examiners
PO Box 48014
Newark, NJ 07101-4814
(215) 590-9500
Request form can be found on the National Board website: www.nbme.org

FLEX EXAM (see chart below for score requirements): Request certification of FLEX scores be sent directly to the Board from:

Federation of State Medical Boards of the United States, Inc.
400 Fuller Wiser Road, Suite 300
Euless, TX 76039-3856
(817) 868-4000 (www.fsmb.org)

FLEX EXAM TAKEN:	MINIMUM SCORE ACCEPTED:
Before 1985	75 weighted average; Passed in one sitting: no scrambling or replacement of scores.
Between June 1985 and December 1993	75 each component; Both components must be passed within 7 years.

USMLE: For approved combinations of NATIONAL BOARD, FLEX and USMLE or to take the USMLE Step 3, see enclosed USMLE information sheet or visit www.usmle.org.

To request scores for USMLE (or combination of USMLE and FLEX), see the NBME website listed above.

UNITED STATES STATE BOARD EXAM: If you did not take any of the above national exams but did successfully pass a state-constructed exam, request state verification with scores. Applicant must have a valid unsuspended, unrevoked license in the state where the exam was taken or in another state where applicant was licensed by reciprocity based on the original state's exam.

COLORADO MEDICAL BOARD
USMLE INFORMATION SHEET

Step 3 of the United States Medical Licensing Examination (USMLE) was introduced with the June 1994 administration of the examination and will be administered thereafter at least twice annually, at such times as may be specified by the Board. The examination requires two consecutive days.

ELIGIBILITY – An applicant must:

1. have obtained an M.D. or D.O. degree;.

2. if a graduate of an international medical school, be certified by the ECFMG (if certification was based on FMGMS you must take USMLE Step 1 and 2);

3. have successfully completed both USMLE Steps 1 and 2 (or another approved combination per attached chart);

4. be enrolled in the first year (or have satisfactorily completed at least one year) of postgraduate training in a program of graduate medical education accredited by the Accreditation Council for Graduate Medical Education of the American Medical Association or by the American Osteopathic Association.

FEES – Contact USMLE for current fee schedule
USMLE Step 3: Call the USMLE Hotline at 1-800-876-5396 to request an application to take the USMLE Step 3 in Colorado, or write to: The Federation of State Medical Boards of the United States, Inc., PO Box 619850, Dallas, TX 75261-9850 (www.usmle.org).

EXAMINATION COMBINATIONS ACCEPTED FOR MEDICAL LICENSURE
IF EXAM PROCESS IS COMPLETED PRIOR TO JANUARY 1, 2000.

Established Examination Sequence	Accepted Exam Combinations
NBME Part I Plus NBME Part II Plus NBME Part III	NBME Part I or USMLE Step 1 Plus NBME Part II or USMLE Step 2 Plus NBME Part III or USMLE Step 3
FLEX Component 1 Plus FLEX Component 2	FLEX Component I Plus USMLE Step 3 Or NBME Part I or USMLE Step 1 Plus NBME Part II or USMLE Step 2 Plus FLEX Component 2
USMLE Step 1 Plus USMLE Step 2 Plus USMLE Step 3	

An examinee who fails USMLE Step 3 may be reexamined at any subsequent examination upon payment of the required fee.

In order to be eligible for a license, an applicant must successfully complete USMLE Steps 1, 2, and 3 within seven (7) years.

Examination scores will be reported using a two digit scaled score. A score of 75 or better on each step shall constitute a passing score on that step. Rounding up of scores shall not be allowed; rather, scores shall be truncated to the right of the decimal. Each USMLE step must be passed individually in order to successfully complete the USMLE examination. Individual step scores shall not be averaged to compute an overall score.

A failure of any USMLE step, regardless of the jurisdiction in which the examination was administered, shall be considered a failure of that step for purposes of obtaining a Colorado license.